

# \*CHILD CARE ASSISTANCE\*

## BASIC ELIGIBILITY CONDITIONS

- The child MUST be enrolled OR eligible into a recognized tribe

## REQUIRED DOCUMENTS

- Copy of child(ren) tribal card/certificate
- Copy of child's birth certificate
- Copy of child's immunization record (must be no more than 1 year old)
- Last 30 day pay-stubs
- Copy of parent(s) Identification Card or Driver's License
- Copy of current rent/lease/mortgage agreement and/or receipts
- Copy of current Utility bill

### Family Application Process

**Program Purpose-** Arctic Slope Native Association provides this child care assistance to clients who are engaged in eligible activities.

**DETERMINATION PROCESS-** Once the application is completed and ALL required documents are provided or updated our staff will process the application then notify you via e-mail or letter whether you have been approved or denied.

- If the client falls within the income guidelines, the client is eligible to receive child care subsidy. The determination will indicate the amount of co-pay that the client will pay. In some cases, ASNA can make a determination to waive the co-pay.
- If the client does not fall within the income guidelines the client is over-income and cannot receive childcare subsidy. The determination will indicate the amount of overage with the income guideline.



## **PLEASE ATTACH 30 DAY PAYSTUB'S**

### **LABOR FORCE STATUS** (PLEASE CHECK MARK ONE)

#### **Are you currently employed?**

- YES
- NO

#### **If yes, please indicate the type of Employment**

- SELF EMPLOYMENT
- EMPLOYER

#### **Are you:**

- PERMANENT
- TEMPORARY
- FULL-TIME
- PART-TIME

**Wage Per Hour:** \$ \_\_\_\_\_ **Are your paydays**      Weekly      Bi-weekly

#### **Is your spouse or significant other currently employed?**

- YES
- NO

#### **If yes, please indicate the type of employment:**

- SELF EMPLOYMENT
- EMPLOYMENT

#### **Is he/her employment:**

- PERMANENT
- TEMPORARY
- FULL-TIME
- PART-TIME

**Wage Per Hour:** \$ \_\_\_\_\_ **Are your paydays**      Weekly      Bi-weekly

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### **EDUCATION and/or TRAINING STATUS**

#### **Are you currently enrolled into college or trainings?**

- YES
- NO

#### **If yes, please indicate the if you are**

- Full time student (12 credits or more)
- Half time student (11 credits or less)
- Attending short-term training (examples: 1<sup>st</sup> Aid/CPR, 40 hour Hazwoper, CDL)

#### **Please indicate if you or your spouse/significant other does not exceed assets over \$1,000,000.00**

- Yes
- No

# **EMERGENCY CHILD CARE RECORD**

(FOR USE BY CHILD CARE PROVIDER)

Name of Child \_\_\_\_\_

DOB: \_\_\_\_\_

Name of Child \_\_\_\_\_

DOB: \_\_\_\_\_

Name of Child \_\_\_\_\_

DOB: \_\_\_\_\_

Name of Child \_\_\_\_\_

DOB: \_\_\_\_\_

Name of Child \_\_\_\_\_

DOB: \_\_\_\_\_

Who has legal custody of children? \_\_\_\_\_

Relationship \_\_\_\_\_

## **Persons authorized to take children listed above from childcare:**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

## **How to reach parent(s) or legal guardians:**

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Phone/cell: \_\_\_\_\_

Phone/cell: \_\_\_\_\_

Guardian: \_\_\_\_\_

Guardian \_\_\_\_\_

Phone/Cell: \_\_\_\_\_

Phone/cell: \_\_\_\_\_

**PHYSICIAN/Name/Address/Phone** \_\_\_\_\_

## **Name, Address and phone number(s) of person(s) who can assume responsibility for the child if parent(s) cannot be reached**

**during an emergency** \_\_\_\_\_

**Allergies (including drugs)** \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

## **CONSENT FOR EMERGENCY MEDICAL OR SURGICAL CARE**

This authorizes \_\_\_\_\_, consent to have the hospital personal provide medical or surgical care for the children list above in the event that I cannot be contacted immediately. It is understood that a conscientious effort will be made to locate me or my child's other parent or legal guardian BEFORE any action will be taken. I understand my obligation to keep my child care provider informed of my whereabouts. I will assume the cost of necessary medical or surgical care.

**Signature of parent or legal guardian** \_\_\_\_\_

**Date:** \_\_\_\_\_

## NOTICE OF CLIENTS RIGHTS ACKNOWLEDGE FORM

**If your application is approved, you will have complete and total authority to select the type of child care you prefer and any specific child care provider as long as the child care provider you identify meets the Tribal certification criteria, and are willing to enter into agreement with the Arctic Slope Native Association Child Care Program to serve as a Provider.**

- I/We certify that I have checked the information on the application very carefully and that it is true and complete statement of facts to the best of my knowledge and belief
- I/We understand that it is against the law to make false statement and that I/we am/are subject to prosecution if I/we do.
- I/We understand that a representative for the Arctic Slope Native Association may call my home and may contact other people in order to verify my eligibility for the childcare assistance. I/we also understand that any information I/we give may be verify by cross matching information with other agencies.
- I/We authorize the Arctic Slope Native Association Social Services Department to communicate with my childcare program.
- I/We certify that this is the only application submitted from or on the behalf of my household for any Child Care Services.
- I/We understand Arctic Slope Native Association is not liable for my choice in childcare provider. Also if my child should be injured or harmed while under the care of child care provider, that I/we will pursue the child care provider and **not** Arctic Slope Native Association.

\_\_\_\_\_  
Signature of Parent or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

# CLIENT AGREEMENT FORM

1. I/We understand that program funds are for use when the parent(s) are engaged in eligible activities. I/We will notify Arctic Slope Native Association Social Service Department **within five days** following a change, which might affect my eligibility. Changes include employment or training status, number of children in family, and income.
2. I/We will secure a provider who will accept my child on attendance or scheduled enrollment basis, and will have a valid authorization agreement before childcare cost are incurred under the program.
3. I/We will give the provider at least **fourteen (14) days'** notice of my intent to terminate childcare services except in the case of sudden program ineligibility, being fired, laid off, increase in wages, etc.
4. I/We will renew our authorization agreement early enough to provide continued care. Authorization agreement cannot be backdated. Any childcare received outside of the effective dates is my responsibility.
5. I/We will sign the provider's **two-week, one-week billing or monthly** statement at the end of the billing period to verify that care was billed only for the times of eligible activity.
6. I/We will pay for authorized childcare costs not paid on my behalf of the program. I/We are responsible for paying the provider for any cost above the maximum authorized subsidy.
7. I/We will pay for childcare if I/we refuse an alternating provider during an unscheduled facility closure.
8. I/We may use more than one provider, however, any costs incurred exceeding the authorized amount or the monthly maximum subsidy is my responsibility.
9. I/We have the right to appeal in writing to Arctic Slope Native Association on decisions made by the local administrator regarding my program eligibility, co-payment of state subsidy, or times for which care is authorized.
10. I/We understand that if I/we do not comply with these responsibilities under this childcare assistance program agreement my authorization for provided childcare assistance will be terminated. I/We also understand that it is fraud to misrepresent facts in order to receive program benefits, including misrepresentation regarding income status, living arrangements, or work status. I/We further understand that any fraud may result in removal from the program and I/We will have to repay any wrongfully used funds.

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

# PAYMENT AGREEMENT FORM

This is an agreement between, \_\_\_\_\_ and \_\_\_\_\_  
(Client) (Provider)

The name above client has been approved into the Arctic Slope Native Association Child Care Assistance Program on \_\_\_\_\_ and will expire \_\_\_\_\_. The name above client is responsible for a co-payment in the amount of \_\_\_\_\_ and Arctic Slope Native Association Child Care Assistance Program will subsidize the approved remaining child care cost.

If, \_\_\_\_\_ owes a co-payment amount to \_\_\_\_\_ it is the **Client's responsibility to pay that portion directly to the provider.**

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In signing this document, we are in agreement and full understanding of the payment process and responsibilities.

\_\_\_\_\_  
Client's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Provider's signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
ASNA Social Service Staff

\_\_\_\_\_  
Date